



# **Community Recovery Resources**

**www.corr.us**

## **Grass Valley Service Center & Administrative Offices**

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## **Transitional Houses**

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**A  
United Way  
Agency**

August 17, 2007

Stuart Drown – Executive Director

Milton Marks Commission on California State Government Organization

925 J Street, Suite 805

Sacramento, CA 95814

Dear Mr. Drown:

Thank you for inviting me to participate as an advisory panel member in the follow up review of the Substance Abuse and Crime Prevention Act (SACPA) of 2000.

Following are comments concerning my views on pertinent SACPA issues:

### ***1. Whether the program is tailored correctly given client type:***

It has been our experience that the client group that Proposition 36 was designed to respond to varies significantly from the actual program participants in many critical ways. Whereas Proposition 36 (P-36) was intended to redirect “first time” offenders who were thought to be initial users with short term addiction histories, the actual clientele has proven to be much more advanced in both its criminal history and its sophistication in addiction cycle.

We have found that those presenting for treatment are much more ingrained in the criminal justice system and by far more entrenched in the addiction cycle. A “first time offense” is not the rule of thumb for those being treated and their needs are much more complex than what was originally expected. Unfortunately many clients are being referred to counselors who are entry level (see attached minimum requirements for only 30% of counselors in licensed facilities by 2010 by the Department of Alcohol and Drug Programs (DADP)) and who do not possess the skills and competencies necessary to address the complex needs and issues of the presenting clients.

The clientele presenting themselves through our program are more representative of heavy users with long histories who are in need of specialized care that can only be provided by experienced and knowledgeable treatment professionals. Given the severity of the addiction status of referred offenders, it is absolutely necessary that administrators develop better resources for assessment and referral of clients. Recognized assessment models, such as the *ASAM Patient Placement Criteria II* given by appropriately trained professionals should be a standard for this program. In addition an orderly assessment of treatment programs available for referral should also be made so that clients can be matched to programs that can provide the appropriate level of care needed, and reassessed a minimum of every 30 days to maximize both the treatment experience for the client and to maximize the tax-payers investment in their treatment. Programs with poor outcome results and abuse and/or incompetence problems should also be noted so that future referrals are not allowed. Would you send a loved one to a treatment program that had poor outcomes and/or staff that had been reported for unethical behavior? Would you expect taxpayers to pay for less than adequate treatment?

## ***2. Opportunities for creating increased success rates:***

California lags well behind other states in its commitment to the quality of care delivered in its public and private treatment centers. Sending offenders to unqualified and/or incompetent counselors, or programs with low outcomes is contrary to what I believe the voters of California envisioned when passing Proposition 36.

I believe the public and the electorate want real treatment that will change the behavior of addicts and stop crowding our prisons. I believe relying on the Department of Alcohol and Drug Programs current regulatory framework to assure Proposition 36 clients quality treatment is foolhardy at best. Only 30 percent of persons providing direct services (counseling) to clients are required to be certified by 2010. Unfortunately even those who are “certified” are certified at a level that is far below the national average. In order to raise success rates, the requirements for the treatment professionals treating P-36 clients must be increased.

No other single reform can increase outcomes more significantly than improving the treatment provided, which is the central issue that determines success or failure for the program.

### **3. Benefits of the Offender Treatment Program:**

I fully support programming that includes direct consequences, such as flash incarceration, for offenders who are unwilling to participate in their own recovery effort. *However, on the other hand I believe that it is extremely unfair to the addict and economically undesirable to the state to refer clients to programs where there are minimally experienced counselors, negligible or non-existent supervision and poor client expectations and then blame the patient or P-36 for failure. Recycling offenders through inefficient and ineffective treatment programs erodes the addict's belief in his or her own recovery effort and degrades the public's trust in treatment as an alternative to incarceration.* In this regard the Offender Treatment Program is a better model, because it returns addicts who continue to use to a safe environment that protects the public. Regardless of the model, practitioners are extremely dismayed by the lack of cooperation in many counties between mental health/health agencies and law enforcement. Better coordination and direct input from health, law enforcement and counselors is imperative for success. Allowing counties to choose between lead agencies with out mandating an advisory panel for oversight leads to compartmentalism and an unbalanced representation necessary to make integral components work together. I believe the model of Drug Courts created by the Judicial is an excellent model with a proven track record and the highest success rates of any treatment model in the Nation.

### **4. The effectiveness of the criminal justice system in curbing addiction:**

I believe using solely incarceration to curb addiction is the most expensive, socially harmful and illogical way to treat addiction. As the methamphetamine epidemic stretches across California and the Nation, this system's ability to respond is being stressed beyond all projections. In 2004 (As reported by TEDS California had over 60,000 admissions for methamphetamine with Washington being the next closest with over 9,000 admissions)(see attached). Until the state seriously considers private financing of our addiction treatment system (parity/licensure of counselors) the justice system will continue to suffer. The simplest alternative to waiting until a person's addiction has reached a stage that involves criminal conduct that draws attention from law enforcement is to simply give addicts access to care earlier in their disease progression. Addicts with access to health insurance that covers addiction treatment can address their issues while still employed and reasonably clear of the criminal justice system. I believe many addicts would be amenable to care well before legal issues would prompt them in that direction if access and social stigma were changed.

Until policy makers submit that the disease of addiction can be adequately treated in its early stages utilizing health care benefits and that standards for addiction professionals must be increased, both offender program approaches will be overburdened with addicts who are entrenched in the addiction cycle due to an inadequate treatment system.

***5. Recommended policy changes:***

The public has put its trust in the success of Proposition 36. In order to salvage that trust, I urge the commission to work toward implementing the following goals:

1. Support draft regulatory amendments that will immediately raise standards for persons giving direct services to addicts being treated in licensed and certified facilities, and that those regulatory amendments pertaining to those providing services require supervision by professionally licensed addiction professionals.
2. Strongly support parity for substance abuse and licensure of alcoholism and drug abuse counselors to create private avenues of effective addiction treatment to ease the pressures placed now on the public system which is the only model available to addicts.
3. Create a 1 year pilot program whereby a random sampling of offenders are directed to facilities where all counselors are fully certified or licensed at or above the national standard. Compare recidivism rates for the pilot program participants versus non-pilot program clients.
4. Create a database that ranks facilities based on important treatment outcome determinants such as: percentage of counselors certified at or above the national level; counselor to client ratios; client supervision parameters; ability to meet law enforcement and judiciary officials' recommendations; and success rates with past offenders. Within the same ranking system, also provide negative credit for; investigations by the DADP; ethics violations by counselors; poor supervision; and occurrences of violence and deaths. Publish this data base as a guide for use by those directing offenders to treatment programs.
5. Create an oversight board or committee in each county where representatives from justice, health and treatment programming can meet regularly to give feedback. Possible expand the role of the currently mandated alcohol advisory committee.

6. Create a cabinet level position within the Governor's office so that a clearer picture of the need to treat addiction as a disease rather than a crime be established and so that addiction issues and their accompanying criminal behavior affecting all Californians can be at the forefront of the Governors reform of State government

California has the largest treatment system in the World along with the greatest addiction treatment needs yet we lag far behind many other states in the level of attention given to this serious health issue and definitely behind in our requirements for professionalism and accountability. Although addiction may not be believed to be the most costly health issue concerning our state I believe if quantified correctly we would find that the cost of addiction is ten fold what we currently know it to be and as such should receive the like amount of attention by the Governor.

I firmly assert that because Proposition 36 clients are being mandated to the care they receive, it is the responsibility of its administrators to ensure that this care is a worthy alternative to incarceration and if not changed then we must also take responsibility for the less than desirable results we are receiving.

By adopting the six recommendations outlined above, California can move forward in addressing this public policy initiative's "Achilles heel." Without quality treatment, and fully qualified counselors at its center, reform of any kind will sorely miss its mark.

Please feel free to copy and distribute these materials as you see fit. If you have any questions, please call me at 530-273-9541 x 213 or 530-923-2421

Sincerely,

Warren Daniels, CADAC II, ICADC – Executive Director  
Community Recovery Resources

Chairman – California Foundation for the Advancement of Addiction Professionals

Past President – California Association of Alcoholism and Drug Abuse Counselors